Section of Proctology

President J C Goligher ChM

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at the General Infirmary, Leeds

The Complications of Homosexuality [*Abridged*]

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Introduction

Any discussion of venereal disease of the anorectal region must stress the importance of homosexual practices as a cause of infection. But not all venereal disease of the anorectum is so conveyed. The most infectious lesions of syphilis, the condylomata lata or syphilitic moist papules of the secondary stage, which are found most commonly round the anus, arise from blood-borne infection and not from contact. Indeed, one or a few condylomata lata may be the only surface lesions of secondary syphilis and they are easily mistaken for primary lesions. It has happened that this has led to an ill-considered accusation of homosexual practice which is deeply resented by heterosexual patients. Many women suffering from genital gonorrhœa also have gonococcal proctitis. Nicol (1948) and Jensen (1953) found gonococcal proctitis in 35% and 31%, respectively, of female patients with gonorrhœa, on proctoscopic examination. Gauss (1938) found this complication in 75% of his patients. This anorectal involvement is usually only detected on proctoscopy. It causes no symptoms or external signs. Opinions differ as to how many of these infections result from anorectal coitus, but spread can and does occur from the genital tract. Contamination of the anal canal probably occurs during defæcation, when increased intrapelvic pressure causes menstrual blood or vaginal discharge to flow over the everted anal mucous membrane. Patients with uncomplicated genital gonorrhœa seldom have much discharge, and it seems likely that spread to the anorectum may occur more often in patients whose genital gonorrhœa is complicated by trichomonal vaginitis, giving rise to a profuse vaginal discharge. As far as I know this point has never been investigated.

Before the advent of chemotherapy and antibiotics, gonococcal proctitis in a male occasionally followed rupture of a gonococcal prostatic abscess into the rectum; but gonococcal prostatic abscess is, fortunately, a thing of the past.

Anorectal lymphogranuloma venereum has generally been regarded as an infection acquired by genital inoculation of the virus, which then sometimes migrates, by the lymphatics, to the perirectal tissue and the rectum. It is symptomatic of the conflicting views which exist, and of the difficulty of obtaining accurate information about such intensely personal matters, that Grace & Henry (1940) considered, from study of many cases at the New York Hospital, that anorectal lymphogranuloma venereum in males was commonly acquired by deposit of the virus upon the perianal region, the anus, or within the lumen of the anal canal or rectum. It was, in fact, a hazard of homosexual practices. They thought that women sometimes transmitted infection to the rectal mucosa by careless use of douches and enema nozzles.

The importance of homosexual practices in the spread of venereal diseases has attracted particular attention recently. It almost seems that these practices are keeping syphilis alive in this country. To give one example, Dr F J G Jefferiss of St Mary's Hospital (1962, personal communication) found that of 113 men suffering from infectious syphilis in 1961, 81 (72%) admitted homosexual exposure and were believed to have so contracted the disease. At the London Hospital the figures are less remarkable: of 35 men with infectious syphilis in 1961, 5 (14%) admitted homosexual contact and were believed to have so contracted the disease. This does not necessarily mean that there are fewer homosexuals in East London. The likely explanation is that they seek each other's company and their meeting places are in the West End. It may well be that they seek advice at West End clinics where their friends may have attended for treatment, and where other patients may be more tolerant of their idiosyncrasies. The incidence of homosexually acquired syphilis may well be greater than these figures indicate, because many

patients are unwilling to admit homosexual practices. It may be that the high incidence of syphilis among practising homosexuals is not a new development but that it has become more obvious through the decline in infectious syphilis in other sections of the population. Harkness (1948), who described his experiences with cases of anorectal gonorrhœa to this Section fourteen years ago, found positive serological tests for syphilis in the cases of 60 (35%) out of 168 men suffering from gonococcal proctitis. At present the incidence of gonococcal proctitis in males has attracted less attention because of increasing genital gonorrhœa.

It is important to know whether men suffering from venereal diseases are homosexuals because these patients often require help with their problems, and so that infectious contacts may be traced and treated. The question 'Have you been with a woman?' elicits the answer 'No' and usually no further information. Questioning about sexual exposures must, if necessary, be direct. It is seldom resented if tactful and courteous. It would be of help in such an approach if there were signs by which homosexuals could be identified. It is said that they are usually able to recognize each other by peculiarities of appearance, habits and mannerisms. The clinician has to be exceptionally experienced to acquire such knowledge. He recognizes the effeminate individual and he may suspect some abnormality from tendencies in dress or hair styles, or from the use of perfumes or cosmetics. It is probably true that it is not usually possible to detect homosexual tendencies from a short medical examination. Many homosexuals are wholly masculine in appearance and behaviour.

That homosexuals tend to keep together and to have clubs and associations has led to the suggestion that the diseases they communicate to each other are unlikely to spread to the general community, because the circle of exposure is closed. This is untrue. Some homosexuals practise both kinds of sexual activity, and some promiscuous people who are not truly homosexual indulge in these practices for stimulation of a jaded sexual appetite. There are some who undertake homosexual activity for gain, but take their pleasures heterosexually.

Interest in homosexuality will impress upon proctologists, venereologists and others that they must be alert to the signs of infectious disease in the anorectal region.

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Anal Syphilis

The problem of excluding syphilis in the diagnosis of anorectal lesions is of obvious importance to the proctologist.

The proctologist might occasionally see an anal primary chancre, and sometimes the perianal condylomata lata of the secondary stage. He is unlikely to see tertiary, i.e. gummatous, lesions of anus or rectum, although this used to be mistaken for the rectal ulceration due to lymphogranuloma venereum in patients who had latent syphilis.

Since the Second World War the incidence of syphilis has fallen, as shown by the annual figures reported in England and Wales by the Chief Medical Officer to the Ministry of Health. The number in 1946 was 23,878; by 1950 it was 9,967, and in 1960 3,946. But in the last five years early syphilis has increased – from 837 cases in 1955 to 994 in 1960. This is not remarkable unless it is realized that it has been associated with an increase in the proportion of admitted homosexuals. Jefferiss (1956) reported that 8·4% of 1,000 consecutive male patients with gonorrhœa or early syphilis in 1954 admitted a recent homosexual contact. Of new patients in 1959, I found that 31·6% with early syphilis were homosexuals (Nicol 1960). Thirty-seven homosexual patients with early syphilis were asked about recent sex contacts. Twelve admitted being the active, and 18 the passive, partner, while 7 were 'versatile'.

There has been an increase in male patients with anal primary syphilis (it is still rare in the female). Homosexuals are often not aware of the risk of venereal disease, so they tend to report to the proctologist for an opinion; it thus rests with him to make a correct diagnosis. This has been emphasized by Hollings (1961) who described 65 cases of anorectal syphilis seen at St Mark's Hospital between 1932 and 1960.

Signs, Symptoms and Diagnosis of Anal Primary Syphilis

The chancre is usually at the anal margin or in the anal canal. It may be a typical single, painless, circular, indurated lesion, but multiple or contact lesions occur, and a primary lesion may develop at the site of a small traumatic lesion such as a fissure-in-ano which is also common in passive homosexuals. The superficial inguinal glands are enlarged, painless, discrete, and of a rubbery consistency. Both groins may be involved and the patient in the secondary stage.

Hollings (1961) lists the symptoms as: Pain on defæcation, anal lump, 'piles', irritation, bleeding, discharge, soreness, and diarrhœa. This is the author's experience also.

Diagnosis depends on (1) dark-ground examination, (2) blood tests, and (3) clinical examination.

(1) Dark-ground examination of the primary or secondary lesions: The serum from an anal chancre should be taken before proctoscopy, for lubricant may interfere with diagnosis. The lesion should be excoriated and squeezed to produce blood-stained serum, which can be collected on a coverslip or by a capillary tube. The patient should be asked about antiseptics or antibiotics applied, taken by mouth or injected, for these will interfere with dark-ground diagnosis. If there has been recent local application, it may be possible to find the *T. pallidum* by gland puncture. A needle is inserted into an enlarged inguinal gland, 0·3 ml of saline is injected, the gland is massaged with the needle *in situ* and some serum withdrawn for dark-ground examination. In the secondary stage, dark-ground specimens may be obtained from skin, mouth, genital or perianal lesions. At dark-ground examination it is important to distinguish the *T. pallidum* from spirochætes of the borrelia group, such as *S. refringens* or, in dark-ground specimens from the mouth, treponemes occurring as dental saprophytes such as *S. microdentium*. This method of diagnosis is available at special treatment centres, to which patients should be referred.

(2) Serological (S.T.S.) tests: i.e. Wassermann (W.R.) and Price's precipitation reaction (P.P.R.) tests should be taken, but results are not available for some days. Negative tests in the early primary stage do not exclude syphilis. In addition, new specific blood tests – *Treponema pallidum* immobilization (T.P.I.), Reiter's protein complement fixation (R.P.C.F.), and fluorescent treponemal antibody (F.T.A.) – are available to exclude false positive reactions to the S.T.S., but these are also negative in the early part of the primary stage. The tests usually become positive during this stage in the following order: F.T.A., R.P.C.F., W.R., P.P.R., T.P.I.

The W.R., P.P.R. and R.P.C.F. can be done as routine laboratory tests. Positive S.T.S. and specific tests may only indicate past treponemal disease, which includes yaws in the Negro. Negro homosexuals are, however, rare.

(3) Clinical examination may reveal anal lesions and regional adenitis. As the patient may be in the secondary stage, the general skin surface should be examined. The face, palms, soles and genitalia may reveal typical lesions. Mucous patches may be seen in the mouth, or flat topped multiple condylomata lata in the perianal region (in addition to the healing anal primary chancre). There may be bilateral adenopathy of the epitrochlear or posterior cervical glands. The history of a recent homosexual contact, and examination and investigation of the contact, may support the diagnosis.

Differential diagnosis: Of the anal conditions, primary syphilis is most likely to be mistaken for carcinoma, hæmorrhoids, or fissure-in-ano. The diagnosis may be made from a biopsy.

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Anorectal Gonorrhœa

Since 1955 there has been a spectacular rise in the incidence of gonorrhœa. It is now the most frequent of the venereal diseases in Britain.

Anorectal gonorrhœa is more common than is generally supposed, and owing to the mildness or absence of symptoms it is often overlooked. The first description of gonococcal proctitis is attributed to Hecker (1801), seventy-eight years before the gonococcus was isolated by Neisser in 1879. The gonococcus was first demonstrated in smears taken from the rectum by Bumm in 1884, the year Gram described the stain which is used to demonstrate the organism.

Harkness (1948*a*) divided anorectal gonorrhœa into primary and secondary types. The primary type was more common in men and usually followed rectal sexual intercourse. It also followed the use of contaminated thermometers, enema nozzles and finger stalls. Secondary anorectal gonorrhœa was more frequent in women as a complication of genito-urinary infection, and in little girls with vulvovaginitis. It was also reported following rupture of abscesses of the prostate, Cowper's glands or the fallopian tubes into the rectum.

Anorectal gonorrhœa in women has been studied by Clements & Hughes (1935) who found 69 cases in 160 women tested, the majority having no symptoms or signs. In 7 of the 69 cases gonococci were found only in the rectum. Nicol (1948) examined 74 women, using proctoscopy in addition to genital tests. Twenty-six of the 74 women had anorectal gonorrhœa. Only 8 of the 26 women with proctitis had symptoms and these were elicited on requestioning when the diagnosis was known. The symptoms were rectal discharge, perianal irritation and discomfort or bleeding when the bowels were open.

Anorectal gonorrhœa is common in women. Infection occurs by direct spread from the genito-urinary tract, from rectal coitus or by accidental infection. Most patients have no symptoms but on questioning may admit to peri-anal

irritation, discharge, bleeding and constipation. The signs are minimal, with a little mucopus on the rectal wall. A considerable amount of pus with congestion of the rectal wall occurs in a few. Examination is with a proctoscope, and diagnosis is by stained smears and cultures of the rectal pus. Gonorrhœa is not infrequently diagnosed only on the rectal findings, tests from the urethra and cervix being negative. Tests of cure in women with gonorrhœa should include smears and cultures from the rectum.

The incidence of anorectal gonorrhœa in men is difficult to estimate. Stühmer (1921) described 26 soldiers who had been infected with rectal gonorrhœa following prostatic massage with a glove contaminated with gonococcal pus. Harkness (1948*b*) attributed all his cases to sodomy.

I have analysed 21 cases of anorectal gonorrhœa in men seen between 1959 and 1961 in hospital and private practice. Rectal intercourse was the cause of infection in all cases. Gonococcal urethritis was also found in 3 patients, all of whom admitted to recent active and passive homosexual exposures. The patients fell into three groups: those with acute, and those with subacute, symptoms and signs; and those who were asymptomatic. Acute symptoms were rare (2 patients), and consisted of severe anal discharge, burning pain in the rectum, blood and mucopus in the stools and extreme pain on defæcation. Proctoscopy revealed a red, œdematous mucosa bathed in profuse pus, which bled easily when touched with a platinum loop.

Subacute symptoms were usually mild and tended to be disregarded. They consisted of anal and peri-anal itching, mild fæcal and purulent staining of the underwear, mucus in the stools, or peri-anal warts. The rectal mucosa was red in patches, with adherent, streaky mucus or mucopus in strands on the rectal wall. The asymptomatic group was examined as a result of contact-tracing because their partners had gonococcal urethritis. The rectal mucosa either appeared normal or showed a few areas of patchy, pale red œdema and in some there was a small quantity of adherent mucus or mucopus on the rectal wall.

Complications occurred in 10 cases. Condylomata acuminata were found on the skin of the peri-anal area and in the anal canal up to the mucocutaneous junction in 6 cases. They were the presenting manifestation in 2 patients. Peri-anal abscess occurred in 1 patient who had acute symptoms and signs and also ulceration of the rectal mucosa. Painful fissuring of the anal canal was observed once. Arthritis, involving the ankle, knee and sacro-iliac joints occurred in 1 patient. There was no evidence of urethritis and no ocular or cutaneous manifestations. The arthritis subsided rapidly following penicillin therapy. One patient developed secondary syphilis during observation following treatment for rectal gonorrhœa. No primary chancre had been detected on repeated proctoscopy, on genital examination or elsewhere on the body. *T. pallidum* were demonstrated in serum from the lesions and serological tests for syphilis became strongly positive. Jones & Janis (1944) drew attention to rectal gonorrhœa and syphilis occurring in the same patient.

The diagnosis of anorectal gonorrhœa is made by smears and cultures from the rectal mucosa, which are stained by Gram's method. McLeod's chocolate agar is satisfactory for culture, but Stuart's transport medium is useful if laboratory facilities are not at hand.

Granular proctitis, ulcerative colitis, non-specific proctitis, lymphogranuloma venereum and carcinoma of rectum have been confused with anorectal gonorrhœa.

Syphilis acquired at the same exposure to infection as the gonorrhœa may be masked by treatment. This is important at present because of the increase in anorectal syphilis. Penicillin is the treatment of choice. Relapse is common, but distinction between reinfection and relapse may be difficult. Relapses following penicillin vary from 60% in a report by Hagerman in 1946 to 5% in one series published in 1954 by Bang. Several authors have stressed the difficulties of treating rectal gonorrhœa. Miescher (1948) reported that anorectal gonorrhœa may persist despite penicillin. Turell (1950) concluded that anorectal gonorrhœa required larger doses of penicillin than infections localized to the genito-urinary tract. Jensen (1953) and others have suggested that the poor results may be due to penicillinase produced by other organisms in the rectum which destroyed the effects of penicillin. Nicol (1948) concluded that the results of treatment with parenteral penicillin appeared to be satisfactory initially, but tests of cure showed that the infection persisted in some cases. He stressed the importance of rectal tests in establishing cure in gonorrhœa.

My practice is to give 600,000 units of procaine penicillin and 200,000 units of crystalline penicillin G in a single intramuscular injection (Avloprocil N.A.). Relapse occurred in 1 case and it was shown by sensitivity studies that the gonococcus concerned was relatively resistant to penicillin. The infection responded to streptomycin.

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Lymphogranuloma of Anorectum

Lymphogranuloma venereum is of world-wide distribution but is rare in this country; 663 male cases and 57 female cases were notified from 1953 to 1961. In 1949 there were 58 male cases and one female case: in 1959 there were 75 male cases and 5 female cases, this steady increase in annual notification being due to West Indian immigration. It is not so rare in Europe, particularly in Scandinavia and in France, where the first description of the disease was given by Bensaude & Lambling in 1936. The three varieties of the disease are:

(1) The inguinal, or climatic bubo, an acute febrile disease, seen mostly in males, and sometimes with concomitant proctitis and acute abdominal symptoms which resemble appendicitis (Nicol *et al.* 1957).

(2) The genito-anorectal syndrome, in which there is œdema, ulceration and destruction of the external genitalia with urinary and fæcal fistula formation, gross perineal scarring and variable spread into the rectum.

(3) The anorectal variety, which is the subject of this paper. This occurs predominantly in women, producing extensive lesions in the pelvic colon, rectum and anus. It may be combined with the genito-anorectal syndrome, but commonly occurs as a lesion confined to the bowels and perineum. This disease is not confined to the rectum but is frequently a proctocolitis affecting the left colon. It is generally conceded that it is the commonest, if not the only, cause of inflammatory stricture of the rectum. The infection probably reaches the rectum by implantation of the virus by spill during intercourse, or through sodomy (males). The incubation period is unknown but a long interval, possibly years, may intervene between infection and the onset of rectal symptoms.

Clinical Manifestations of Anorectal Lymphogranuloma

Of 91 rectal cases that I studied recently in the West Indies, only 6 were males. The average age was 40. The anorectal variety is seen in two overlapping phases, the proctocolitis or subacute stage, and the stricture or chronic stage. The symptoms vary but in general the first complaint is of copious bloody pus *per rectum*, spurious diarrhœa, or the passage of narrow pencil-like stools. Cramp-like abdominal pain may be present with distension suggestive of chronic obstruction, and occasionally acute obstruction occurs. These symptoms are often tolerated for months or years, and the patients become anæmic, debilitated and show many toxic manifestations. They may present with fistula-in-ano, ischiorectal abscess or rectovaginal fistula.

Rectal Lesions

The perineum may show multiple discharging sinuses with large condylomatous lesions surrounding the anal orifice. A rectovaginal fistula may be present, situated characteristically at the anorectal ring. There may be no external lesion, however, proctitis being the commonest presentation. The granular proctitis has a typical feel resembling morocco leather; larger polypoid granulations can often be felt, and the rectum is thickened and inelastic, so that the finger appears to be gripped by it, and on withdrawal is followed by a considerable amount of pus. The rectal surface is velvety and bright red, with darker areas of punctate hæmorrhages. Small shallow ulcers are seen. In most cases the severe infection is limited to the anus and the rectum, but lesions may extend above the length of the sigmoidoscope.

The established rectal stricture is 3–5 cm from the anal margin. It may vary from slight narrowing of the rectal lumen to almost complete stenosis. In the recent case it is soft, easily split by the finger, often with considerable hæmorrhage. In a longstanding case, the tissues are leathery and bar further entry of the finger. The stricture varies in length and shape and may be diaphragmatic, tubular or conical, though some combination of these is usual.

The upward extension of the stricture cannot always be appreciated by the finger, for many extend above the rectum. The large bowel is affected to a varying degree by colitis and stricture.

Treatment

The broad-spectrum antibiotics cleared the proctocolitis in 80% of my cases, although the complement-fixation titre is not usually significantly lowered. The established stricture is either dilated or excised. Dilatation is satisfactory in early cases but must not be forceful, for dangerous hæmorrhage can occur and fibrosis rapidly recurs. Excision of the severe stricture is indicated.

Colostomy is unsatisfactory, for the disease continues to progress. Rectal discharge persists (though reduced in degree), and malignant change may supervene in the stricture. Abdomino-

perineal excision must be done in cases with complete destruction of the anal canal and recto-vaginal fistula – and a very difficult operation it can be.

In view of the sex and young age group of these patients, all who have had to deal with the disease have sought an operation which leaves a functioning anus. In 1930 Hartmann described 47 cases of inflammatory stricture treated by his operation, which he called intrasphincteric amputation. This was before the ætiology of the disease was known and Hartmann's only comment on the cause was 'sex certainly plays a part in this disease'. My small series of restorative operations include 7 abdominal 'pull-throughs' and 2 Kraske abdominosacral operations – 9 in all – producing good results in 4, satisfactory in 2, and poor in 3. Annamunthodo (1961), in his Hunterian Lecture, showed better results using an endo-anal procedure, broadly similar to Hartmann's operation, described by Dimitriu & Gregoresco (1933).

There is little anorectal lymphogranuloma in Britain to-day. Enquiries in Birmingham and Liverpool reveal no cases seen in surgical clinics. From St Mark's I have found 2 cases in twelve years. I am grateful to Dr Basil Morson and the Medical Committee of St Mark's for allowing me access to their records. These two cases are both of special interest:

Case 1
Male, aged 33, presented with suppurative inguinal glands and a granulomatous anal lesion. An operation for 'piles' was done. The operation area, six weeks after the operation, was described in the notes, curtly but graphically, as 'rather a mess'. Two months later Frei and complement-fixation tests were strongly positive and sigmoidoscopy then revealed a cobble-stone proctitis. The lesions cleared after a course of chloramphenicol. This was a white male, and he had suppurative buboes concurrently with a localized anal lesion and proctitis.

Case 2
A Negro woman, aged 49, had an anal stricture with a positive Frei test in 1953. She attended again in 1960 with aggravation of her symptoms. The stricture was biopsied and showed a squamous-cell carcinoma. A successful synchronous combined excision was done.

Carcinoma supervening on chronic inflammatory rectal stricture has been described frequently. Rainey (1954), from the Cook County Hospital, Chicago, found 8 cases of rectal carcinoma (5 squamous and 3 adenocarcinoma) in 220 cases of stricture, an incidence of 3·6%. The average age of these female patients was 47, at which age the expected incidence of carcinoma is low.

Anorectal lymphogranuloma is preventable if the primary phase is diagnosed and treated vigorously, and it is still curable in the subacute stage by nonsurgical means. The established stricture with irreversible changes in the adjacent bowel must be treated by radical surgical measures aimed at eliminating what may be a potentially malignant condition.

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Papers

The Results of Surgical Treatment of Fissure-in-ano [*Summary*]

by R C Bennett FRCS
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The results of surgical treatment of 172 patients for fissure-in-ano were reviewed: 127 cases treated by internal sphincterotomy and 45 by sphincter stretch. The purpose was to assess the reliability of these procedures in relieving symptoms and healing the fissure, and the effect on anal control.

After internal sphincterotomy recurrent symptoms were noted in 7%, but in only half of these was an active fissure present on examination. Minor defects in anal control relating to the inadvertent passage of flatus or fæces or frequent and unaccustomed soiling of underwear were noted in 43%, compared with 11% of people of the same age and sex who had not had an anal operation. The commonest defect was soiling, which occurred in 28%. Neither the incidence of defects nor that of recurrence was related to the amount of internal sphincter divided. The average time off work was seventeen days.

After sphincter stretch, 20% complained of persistent or recurrent symptoms, but half of these were relatively satisfied and did not require internal sphincterotomy. Only 13% had minor defects in anal control (2 only with soiling). The average time off work was seven days.

[This paper will be published in full in the *British Medical Journal.*]

The following papers were also read:
Motility Studies after Fissure Operations
Mr H L Duthie
Segmental Colitis and Crohn's Disease of the Colon
Dr H Thompson
(to be published in *Brit. J. Surg.*)